LORI KOLODIN, MPH, RD
REGISTERED DIETITIAN IN PRIVATE PRACTICE

786 MOUNTAIN BOULEVARD, SUITE 205
WATCHUNG, NEW JERSEY 07069
PHONE 908-403-7636
FAX 908-222-0020
LSKNUTRITION.COM

PATIENT INFORMATION SHEET

please print clearly

Name:

Address:

City:

State & Zip:

Telephone to best reach you:

Email:

Date of birth:

Initial visit date:

Occupation or student:

How many in your household?:

Referred by & reason for visit:

Primary Insurance:

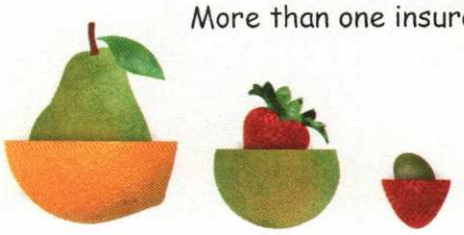
Name & date of birth of policy holder:

Relationship to patient (circle one): self spouse parent

Policy number & group number:

Address of insurance company:

More than one insurance?: YES NO



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FINANCIAL POLICY

The purpose of my practice is to provide you with the best possible care. If you have health insurance, I am committed to helping you receive maximum allowable benefits. In order to achieve these goals, I need your assistance and understanding of my payment policy.

It is the patient's responsibility to verify their medical benefits prior to their initial visit. Being in network does not guarantee reimbursement of services rendered. All referrals, authorizations and co-payments are due at the time of service and it is the patient's responsibility to understand how their insurance policy works and exactly what is expected of them in terms of referrals, co-payments, authorizations and deductibles.

Cancellations less than 24 hours prior to scheduled appointments will be charged a $30.00 fee unless a true emergency occurs.

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I understand and agree that regardless of my insurance status, I am ultimately accountable for all charges for professional services rendered to myself or my dependent. I have read the information above and verify that all information is correct on my patient information sheet. I hereby give Lori Kolodin, MPH, RD permission to release my or my dependent's medical records to my insurance company should they require additional information.

Signature: Date:

Print name:

Parent signature (if minor):

Print name: Date: